Managed Risk Medical Insurance Board
Minutes of May 21, 2003, Meeting

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Virginia Gotlieb, Sandra Hernández, M.D.
Ex Officio Member Present:	Ed Mendoza
Staff Present:	Lesley Cummings, Joyce Iseri, Laura Rosenthal, Lorraine Brown, Irma Michel, Tom Williams, Dennis Gilliam, Mercedes Kneeland, Mauricio Leiva, Vallita Lewis, Janette Lopez, Cristal Milberger, Cynthia Moore, Ernesto Sanchez, Doug Skarr, Teresa Smanio, Dinorah Torza

The meeting was held at the State Personnel Board Auditorium in Sacramento.

Chairman Allenby called the meeting to order.

REVIEW AND APPROVAL OF MINUTES FROM APRIL 23, 2003, MEETING

Virginia Gotlieb made a motion to approve the minutes of the April 23, 2003, meeting as distributed. The motion was unanimously passed.

BUDGET UPDATE

Tom Williams, Deputy Director of Administration, presented highlights of the 2003-3004 Finance Letter and May Revision. Both documents continue to reflect the Administration's support for the programs MRMIB administers.

Spring Finance Letter

The Spring Finance letter included three proposed changes that impact MRMIB. These changes were approved by the Senate Committee but remain open in the Assembly Committee. The Letter requests (1) $2.9 million dollars to implement the Insurance-based Oral Health Initiative Demonstration Project; (2) $153.8 million in funding and the adoption of trailer bill language to enable MRMIB to fund projects from county-based initiatives under AB 495; and (3) $220 million in General Fund to replace in Tobacco Settlement Funds (TSF) .

May Revision

Current year. The May Revision fully funds the Healthy Families Program (HFP) to serve a projected enrollment of approximately 669,000 children by June 30, 2003. Overall enrollment in the current year is less than 0.4% under the projected enrollment used in the 2003-04 Budget. Due to minimal program growth, it is anticipated that the end of year numbers will be close to projections. The AIM program is fully funded to serve the projected enrollment of approximately 8,000 new uninsured, pregnant women (670 women per month) and a monthly average of 10,000 infants.

Budget Year. The HFP is fully funded for 2003-04 with $794.5 million to serve a projected enrollment of 726,625 children by June 30, 2004. The projected enrollment is down about 5.4% from the January estimate. The growth rate in enrollment was adjusted to reflect the anticipated impact of the loss of funding for outreach and application assistance fees. The May Revise restores $173.4 million in Tobacco Settlement Funds (TSF) which reduces the need for General Funds contained in the Spring Finance Letter. It also reduces funds for enrollment associated with the CHDP Gateway estimate from $20 million to $5 to 6 million, to reflect more recent enrollment estimates from the Department of Health Services (DHS).

The AIM Program is fully funded for 2003-04 at $122 million to serve 9,000 new uninsured, pregnant women (745 women per month) and a monthly average of 12,400 infants. This reflects a 6.2% decrease in enrollment. Funding for outreach and application assistance fees was eliminated and the savings directed to address the rate increases. Growth rates were adjusted down to take account of the drop in enrollment. Funding for MRMIP is maintained at $40 million level.

Mr. Williams noted that the Legislative Analyst's Office had recommended approval of MRMIB's enrollment projections for AIM and HFP. The Assembly proposed the elimination of the sunset date for the rural health demonstration projects, but did not appropriate any funds for it. Dr. Areta Crowell asked if the legislature discussed the elimination of outreach money. Mr. Williams indicated that they had not.

Chairman Allenby asked if there were any questions or public comment. There were none.

LEGISLATIVE UPDATE

Bill Summary

Teresa Smanio, Legislative Coordinator, reviewed the legislative bill summary with the Board. She noted that May 31 is the last day for the Appropriations Committees to hear fiscal bills and June 6 the last day for one-year bills to be passed by the house of origin.

Chairman Allenby asked if there were any questions or public comment. There were none.

Overview of Health Reform Legislation

Laura Rosenthal, Chief Counsel, provided a summary to the Board on health reform bills introduced during the 2003-04 legislative session. Most of these have a significant impact on MRMIB. She indicated that the purpose of her discussion was not to present a full analysis of each bill, but rather to make the Board acquainted with the major proposals in the legislature. Bills she summarized were: AB 30 (Richman); AB 1527 (Frommer), AB1528 (Cohn), SB 2 (Burton), SB 921 (Kuehl).

Regarding AB 1528 (Cohn), which includes an individual mandate, Chairman Allenby asked if the bill also included reforms in the individual market. Ms. Rosenthal stated there are market reforms and MRMIB will administer the purchasing pool for those employers that paid for rather than provided coverage. Chairman Allenby asked if the major reform bill addressed the ERISA issue. Ms. Rosenthal replied that they did not. Chairman Allenby commented that at some point authors would have to address the ERISA issue.

AB 373 (Chu)

Teresa Smanio, Legislative Coordinator, presented an analysis of AB 373 (Chu), sponsored by the California Primary Care Association (CPCA). This bill deems an HFP subscriber to be assigned directly to a primary care clinic rather than an individual provider when the subscriber has selected a provider working at the clinic as his or her primary care provider (PCP). This allows subscribers to continue their relationship with their primary care clinic in the event that the selected provider leaves the clinic. MRMIB's suggested amendments to the bill include: reaffirming the right of HFP subscribers to change their assigned PCP to a primary care physician consistent with current Knox-Keene Act requirements; changing the implementation date to be consistent with the start of the HFP contract period (i.e., July 1, 2004); and specifying that the bill applies only to HFP health plans, not dental or vision plans. The bill is modeled on similar legislation (AB 2674), enacted last session, and concerning Medi-Cal managed care plans.

Virginia Gotlieb asked if the desire to remain associated with a clinic was valid for vision and dental services as well. Lorraine Brown, Deputy Director of Benefits & Quality Monitoring, responded that very few clinics had vision services and that not all of HFP's dental plans contracted with clinics or designated PCPs. She noted that the legislation enacted last year for Medi-Cal only concerned health coverage and that those HFP plans also contracting with Medi-Cal would like HFP to be consistent with the Medi-Cal program. Ed Mendoza asked if it was possible to make Medi-Cal consistent with this bill instead. It would be beneficial to the subscriber to offer the same option to choose a clinic as a dental provider as well as a health provider. Mr. Mendoza asked why HFP should be consistent with Medi-Cal as HFP has an opportunity to set new health standards. Lesley Cummings, Executive Director, indicated that to ensure that subscribers could chose a clinic as its dental PCP as well as its health PCP would

require that MRMIB dictate to its plans who their providers would be and whether or not they would use a primary care provider approach.

Chairman Allenby asked for comments from the audience. Debra Reidy Kelch, representing CPCA, the bill's sponsor, stated that CPCA intends to clarify that AB 373 refers to health, dental and vision plans. When asked by Mr. Mendoza if CPCA agreed with MRMIB staff's amendment to specify that the bill applies only to HFP health plans and not dental or vision plans, Ms. Kelch stated that CPCA does not. Dr. Hernández asked if AB 2674 addressed this issue in regards to Medi-Cal. Ms. Kelch stated that this issue was not addressed during discussions of AB 2674. Chairman Allenby asked if staff originally tried to develop a "road map" for involvement of clinics in HFP. Ms. Michel stated that staff originally worked with clinics and encouraged them to participate in HFP through health plans.

Chairman Allenby asked what would happen if a subscriber goes to a clinic they have been assigned to for health services and the subscriber sees a dentist at that facility. If the subscriber has Delta Dental and the dentist is not a Delta Dental provider, would the services be covered? Ms. Michel stated that the dentist would be considered out-of-network and the services would not be covered. Dr. Hernández stated that it would be helpful to know how many dentists in HFP have a relationship with clinics.
Ms. Cummings stated that, generally, Dental Provider Organizations (DPO) have relationships with clinics and Dental Maintenance Organizations (DMO) do not.
Dr. Hernández asked if health plans have responded to AB 373. Ms. Brown responded that there is no opposition from plans as long as it remains consistent with the Medi-Cal program. Dr. Hernández stated that the program should consider developing incentives for dental plans to include clinics in their networks. Ms. Cummings stated that the Board's input on the topic is useful since MRMIB will be developing a new model contract for plan reprocurement in the fall. Ms. Kelch indicated that it was not the sponsor's intent to restructure the Board's contractual relationships, and that CPCA would continue to work with MRMIB staff on the issue.

Chairman Allenby asked if there were any additional questions or public comments. There were none.

AB 1163 (Frommer)

Ms. Smanio presented an analysis of AB 1163 (Frommer) sponsored by the 100% Campaign. The bill requires MRMIB and DHS to implement system and program changes in HFP and Medi-Cal enrollment and eligibility processes with the goal of improving retention of children in the programs. The estimated fiscal impact to implement the bill's provisions is $24.0 million ($8 million General Fund) annually in addition to indeterminate administrative costs. The analysis described several concerns regarding the installment plan for delinquent premiums, the new bridge to county health programs, synchronizing Medi-Cal and HFP renewal dates, changes in current bridge programs, and lack of reimbursement for MRMIB administrative costs, among other provisions. Significant costs were estimated for the provisions permitting self-

declaration of income at the HFP Annual Eligibility Review and eliminating current time limits for the Medi-Cal to HFP and HFP to Medi-Cal bridges

Dr. Crowell asked if staff would continue to work with the author to resolve these problems. Ms. Cummings responded that staff have participated in several meetings with the sponsor and will continue to do so. She noted that copies of the analysis had been provided to the sponsor and author the prior evening as soon as the analysis was completed. She apologized that they had not had time for a more thorough review.

Chairman Allenby asked for any public comment or questions. Kristin Testa, representing the 100% Campaign, the bill's sponsor, thanked staff for their assistance on AB 1163, the purpose of which is to improve retention of HFP and Medi-Cal coverage. Ms. Testa noted that the estimated costs for the bridge provisions indicate that children are falling through the cracks between Medi-Cal and HFP. She further pointed out the estimate on the cost of doing self-certification at renewal did not recognize administrative savings that would occur because of reductions in staff workload, and noted that other states are doing self-certification. Because accelerated enrollments in the existing bridges are not time limited and the bridges were approved by the federal government, she felt it is fair to assume that the bridges provided in AB 1163 would be the same. Ms. Testa stated that she understands synchronizing Medi-Cal and HFP will be difficult, but that establishing a single point of entry was also difficult but worth accomplishing. She concluded by saying the 100% Campaign is looking forward to working with MRMIB staff on these issues.

Mr. Mendoza asked whether disenrollment due to nonpayment of premiums is significant. Ms. Testa replied that it is likely a very small number. Mr. Mendoza stated that the operational issues associated with the installment plan proposed in AB 1163 seem quite difficult in relation to the small amount of subscribers it would address. Dr. Crowell stated that staff has an excellent record in improving and simplifying the program.

Chairman Allenby asked if there were any additional questions or public comments. There were none.

SB 142 (Alpert)

Ms. Smanio presented an analysis of SB 142 (Alpert), sponsored by the County Welfare Directors Association. SB 142 establishes a Medi-Cal to HFP accelerated enrollment program to provide temporary health benefits to children who have applied for and been determined eligible for Medi-Cal with a share of cost but who appear to be HFP eligible. These children would receive Medi-Cal fee-for-service while on the accelerated enrollment program until they are enrolled in the HFP. The fiscal impact of the bill is estimated to be $3.7 million ($1.4 million General Fund) for benefit costs during accelerated enrollment; $ 153,000 ($ 57,000 General Fund) in county administrative costs; and undetermined costs to the HFP associated with children who are ultimately enrolled in the program.

The analysis suggested several amendments to clarify eligibility for the new program, as well as to limit program and administrative costs. Additionally, MRMIB staff recommended an amendment to clarify that the bridge benefits terminate on either the effective date of the HFP coverage or the date the child is determined ineligible for the HFP, instead of when the child is discontinued from the MEDS file.

Ms. Smanio indicated that the sponsor has agreed to the amendments MRMIB proposed. SB 142 was heard on May 19, 2003, by the Senate Appropriations Committee and was placed on the committee's suspense file.

Ms. Gotlieb asked about discontinuing a child from the MEDS data file before a clear determination of HFP eligibility has been made. Ms. Michel responded that MRMIB's recommended amendment on the termination date for bridge benefits would ensure that county staff, who have the capability to drop a child from the MEDS file, would not discontinue a child from MEDS, and would instead return the application to HFP for eligibility determination. Chairman Allenby commented that this bill was a work in progress.

Chairman Allenby asked if there were any questions or public comment. There were none.

REVIEW AND APPROVAL OF 2003-2004 INTERAGENCY AGREEMENTS

Chairman Allenby reviewed the 2003-2004 Interagency Agreements for Board action:

a. State Controller's Office - Expedited Payments
b. Health and Human Services Data Center
c. Health and Human Services Data Center – CALSTARS Support
d. Department of General Services/Office of Administrative Hearings – Administrative Hearings for Board Programs
e. Department of Health Services – Federal Funding for Single Point of Entry Process
f. California State University Trustees – Graphic Arts Consultation and Development from California State University, Sacramento, University Media Center
g. Health and Human Services Agency - Representation and Administrative Support

Dennis Gilliam, Contracts Administrator, stated that when the meeting agenda had been mailed out, staff were still researching whether Health and Human Services (HHS) Data Center or Teale Data Center would best serve MRMIB's needs. Since then, staff had concluded that the HHS center would be the better choice.

Ms. Gotlieb asked if the agreement with the Department of General Services for administrative hearings was set up as a retainer or on a fee-for-service basis. If not

spent, would the monies be returned to MRMIB? Laura Rosenthal confirmed the funds would be paid only if MRMIB had hearings. Dr. Crowell commented that the language should clearly indicate this in the IAA. Dr. Hernández made a motion to approve all interagency agreements submitted before the Board by approving the resolutions included with agenda item 4. The motion was unanimously passed.

HIPAA CONSULTANT CONTRACT UPDATE

Joyce Iseri, Chief Deputy Director, presented an update on the HIPAA consultant contract. At the April meeting, the Board had authorized the Executive Director or her designee to enter into an interagency agreement with the California Office of HIPAA Implementation for MRMIB to receive $150,000 in one-time funds to assist with HIPAA implementation and compliance efforts. The Board had also authorized the Executive Director or her designee to select and contract with an outside consultant in these efforts. MRMIB received proposals from five vendors to serve as consultants, and staff had narrowed the selection to two consultants and were checking references. The final decision was expected to be made within the next week so the contract could be executed in June.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry Reports

Ernesto Sanchez reported there were 673,000 children enrolled in the HFP as of May 21, 2003. He briefly reviewed enrollment data that included the ethnicity and gender of subscribers, the top five counties in enrollment and Single Point of Entry (SPE) statistics. He noted that 59% of applications received through SPE were forwarded to HFP and 61% of applications were assisted by enrollment entities or CAA.

Chairman Allenby commented that high enrollment numbers raise questions about the enrollment projections. Dr. Hernández asked how the elimination of application assistance payment would affect enrollment.

Lesley Cummings noted that the growth rate for the current year had been estimated at around 19% during a year for which outreach funds for community based organizations and schools had been eliminated. The program has in fact experienced a 19% growth rate during the current year and it is not clear whether the impact from loss of the outreach funds would affect enrollment later. In January, for the budget year, the program was budgeted at a 9% growth rate, a rate that was reduced in the May revise to 7%. In the absence of knowing the impact of first outreach grants and now application assistance payments, staff had made an adjustment down from the growth rate in the current year.

Dr. Hernández commented that it would be helpful to track agencies impacted or associated with the elimination of application assistance. She asked if there was a structure available in the new administrative vendor contract to assist those who can

continue the work. Dr. Crowell asked if application assistants were significantly involved with re-enrollment as well as initial enrollment. Ms. Michel replied the percentage of renewals associated with application assistants was very low. She said that the new administrative vendor contract does provide for continued training and certifying of application assistance, for those who want to continue providing assistance without payment. MRMIB is now able to – and will continue to – track applications received from assisters. Ms. Cummings stated the estimate on those eligible for, but unenrolled in, HFP has changed significantly over time. If enrollment estimates are correct fn the budget year, HFP will come close to – and may surpass – the total number of eligible but unenrolled identified in the California Health Interview Survey of 2001. However, the survey is 2 to 3 years old and significant changes have occurred in the economy. The next survey will provide new projection estimates. Dr. Hernández asked if staff had looked at the survey data in light of the racial privacy initiative. Ms. Cummings replied that staff had not.

Chairman Allenby asked if there were any questions or public comment. There were none.

Administrative Vendor Performance Report

Mr. Sanchez presented the Administrative Vendor Performance Report for April 2003. Electronic Data Systems (EDS) is the administrative vendor for the HFP and SPE. EDS met all seven-performance standards for HFP and all four performance standards for the SPE. Ms. Cummings stated MRMIB has appreciated EDS' cooperation in working to ensure that the transition goes smoothly.

Chairman Allenby asked if there were any questions or public comment. There were none.

Retention Report

Irma Michel presented a report on retention and disenrollment for children enrolled from January 2001 to December 2001. This report was an update to one previously provided to the Board on retention and disenrollment from June 1998 to December 2000.

The most recent report found that 69% of children remained in the program after Annual Enrollment Review (AER). Twelve percent disenrolled during the first year and 19% disenrolled during AER. This compares to 66% found in the earlier report.

A breakdown of the families disenrolling after one year show that 9% left due to unavoidable reasons such as income changes, the child moved out of the parents' home, or the child aged out. Twenty-two percent left for "possibly avoidable" reasons, for information not supplied at AER, or nonpayment of premiums. The NASHP retention study done in 2001 indicated that 60% of the families who were disenrolled for "possibly avoidable" reasons deliberately chose to become disenrolled because they either felt

they no longer needed coverage or concluded they were ineligible and failed to inform the SCHIP program. This leaves 9% who were actually disenrolled for "possibly avoidable" reasons. Mr. Mendoza asked if the NASHP report indicated what these reasons might be. Ms. Cummings replied that it did. Ms. Michel reported that the program had learned from the NASHP focus groups and made improvements to address a number of issues identified. These changes were implemented in mid-2001, the year being reported on.

Dr. Hernández noted that the "avoidable" reasons for disenrollment were decreasing. Ms. Michel stated that the changes implemented in 2001, such as making phone calls and sending additional information to families, increased the number of families remaining in the program. Chairman Allenby commended Ms. Michel on the report and expressed appreciation for her work.

Chairman Allenby asked for public comment.

Kristin Testa of the 100% Campaign testified that this progress was exceptional news. She expressed her appreciation to MRMIB staff for reporting it. She notes that the NASHP report includes self-reported information on eligibility. Some families do not fully understand the rules and may be losing coverage because of this. But even if the number losing coverage for avoidable reasons is only 9%, AB 1163 could allow coverage for these people. Mr. Mendoza commented that AB 1163's systems of bridges could become over-complicated. He recognizes the need for continuous coverage, but notes that it could be very costly to provide 9% with other coverage. Kristin Testa responded that it would be costly not to provide it. If AB 1163 is enacted and implemented, many children will not fall through the cracks between Medi-Cal and HFP anymore. Ms. Michel commented that the information in the NASHP report came before a lot of the improvements in HFP, so the situation should be much improved. For example, HFP now makes reminder calls to families. The administrative vendor has found that fewer families have requested assistance on their AER form since the changes were implemented.

Chairman Allenby asked if there were any questions or public comment. There were none.

Administrative Vendor Transition Status

Ms. Cummings began the presentation by acknowledging that the transition was in its initial stages. A progress report with milestones and dates will be provided at subsequent meetings. Ernesto Sanchez then provided the Board with an overview of the transition activities thus far.

MRMIB and Maximus staff began the transition kickoff meeting on April 23, 2003. This was the first of regular weekly progress meetings that will run through the entire transition period. On May 12, Maximus activated the project internet website which provides transition team members real-time access to the pertinent transition

documents. In addition, Maximus has selected and hired the architect and general contractor that will prepare the HFP/SPE/AIM facility for occupancy. The architect has completed the first draft of the facility design plan. Maximus has submitted updated components of the Transition Work Plan in accordance with the contractual requirements. Maximus is working with MRMIB and DHS to provide transition milestones for dissemination to the Board at its next meeting.

Mr. Mendoza noted that the current vendor, EDS, had indicated it would provide full cooperation during the transition. He inquired about the costs for the current vendor's transition. Mr. Sanchez responded that the contract with EDS has turnover requirements which are funded in that contract. Staff received the message of cooperation from the current vendor with great appreciation. Ms. Cummings reported that both she and Ms. Michel are personally meeting with the current vendor to ensure that this transition is a success.

Chairman Allenby asked if there were any questions or public comment. There were none.

Advisory Panel Summary

Irma Michel presented a summary of the Panel's activities in Chairman Jack Campana's absence. The Panel met on May 6, 2003, in Sacramento. The next meeting will be on Tuesday, July 29.

The Panel was pleased with the results of the Health Status Assessment Report. Panel members expressed a desire to review similar studies to compare the results with HFP. It thought that such studies should also occur for the Medi-Cal population and asked the DHS staff attending the meeting to find out whether such studies had been done. The Panel also asked Doug Skarr, Research Program Specialist, to follow up with the study's author, Dr. Jim Varni, about any studies being done by Medi-Cal or research beyond HFP. The Panel suggested that the Department of Health Services receive a copy of the Study's results.

MRMIB staff asked the panel for input on SB 59 (Escutia), which requires MRMIB to report on how SCHIP dollars could be used to address the needs of vulnerable populations. Panel members suggested that the funds could be used to focus on the health care needs of autistic, undocumented, and homeless children. Services could also be extended to provide case management services for troubled kids and address absenteeism for children with asthma. Another suggestion was to expand HFP to cover 300% of the federal poverty level (FPL).

Dr. Crowell recommended that the Panel's minutes be put on MRMIB's website, even in draft form. Chairman Allenby agreed that this would be valuable.

Chairman Allenby asked if there were any questions or public comment. There were none.

Advisory Panel Vacancies

Irma Michel reported that the Panel reviewed applications for its vacancy for a subscriber with a special needs child. Staff recommends that Ms. Margaret Jacobs of Grass Valley, California, fill this vacancy. Ms. Jacobs' child has been an HFP member since 1991. She is very interested in being on the panel and very supportive of the HFP. Dr. Crowell asked that a copy of her application be distributed to the Board.

Ms. Cummings noted that there are vacancies on the Advisory Panel for a county public health representative and a health plan community representative. Ms. Michel stated applications have been received for the health plan representative and they are advertising for both vacancies on MRMIB's website.

Chairman Allenby made a motion to approve the staff's recommendation to approve Margaret Jacobs to the Advisory Panel. The motion was unanimously passed.

Update on Outreach Work Group

Ms. Michel provided the Board with an update on the convening of the Outreach Work Group.

The Work Group, comprised of Community Based Organizations (CBO), health plans, advocates, stakeholders, and Advisory Panel members, provides a place where those who wish to help families enroll in the HFP can brainstorm ways to do so in the absence of state funds. To this end, the Work Group has asked any CBO interested in outreach activities to send a letter to MRMIB detailing their experience and the areas in which they can provide training. MRMIB will perform the training certification and keep a record of whom the CBO trained. The 100% Campaign and Consumers Union will be sending out a notice to all enrollment entities to see who wishes to continue their participation in outreach activities. MRMIB staff will be sending out a notice to health plans to see if they will update their marketing strategies.

MRMIB staff will be meeting with DHS to review the media available and post it on MRMIB's website (www.MRMIB.ca.gov). MRMIB's website will be used as a source for all CBOs that wish to participate. The Packard Foundation that funds School Connections has moved their staff person to MRMIB. She continues to work on outreach to schools.

Chairman Allenby acknowledged the California Teacher's Association's helpfulness.

Chairman Allenby asked if there were any questions or public comment. There were none.

Report of Consumer Survey

Lorraine Brown, Deputy Director of Benefits and Quality Monitoring, began the presentation by introducing Cristal Milberger of MRMIB Staff. Ms. Milberger is the staff liaison to Datastat, Inc., the independent vendor that conducted the health and dental plan surveys for MRMIB. Ms. Milberger provided an overview of the report's findings for health plans and dental plans participating in the HFP. Both surveys were conducted to assess the satisfaction and experience families had with participating plans and to provide existing and potential HFP applicants with consumer satisfaction information about their plan choices.

Health Plans

The health plan survey was conducted using the Child Medicaid version of the Consumer Assessment of Health Plan Survey (CAHPS®) 2.0H instrument. The instrument contains questions pertaining to nine aspects of care, including: customer service, communication of providers, access to care, and quality and satisfaction of health plan services and health care received. The survey was conducted in five languages - English, Spanish, Vietnamese, Korean, and Chinese.

The response rate for the 2002 survey (65.1%) was slightly higher than the response rate for the 2001 survey (62.4%) and represents the highest response rate to date. The survey responses were summarized into four rating and five composite questions. For the four rating questions, a 10-point scale was used to assess overall experience with health plans, providers, specialists and health care. The results of the survey indicated that at least 80% of families rated their health care, health plan, personal doctor (or nurse) and specialist an 8, 9, or 10. The highest score achieved for the program overall was for *rating of health plan* at 87%. The lowest rating for the program overall was for the *rating of the specialist* at 80%. Regarding scores for individual plans, 92% was the highest score for *overall rating of a health plan*. The lowest score for a plan was 71% for *rating of personal doctor or nurse*. The percentage of families rating their health plan an 8, 9, or 10 increased from 85% in 2001 to 87% in 2002.

Composite questions were grouped with other questions that relate to the same broad domain of performance: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, and *Customer Service*. Eighty percent or more of families responded positively for most of the composite ratings. For the program as a whole, the rating with the highest percentage of families responding positively was for *How Well Doctors Communicate* questions, at approximately 88%. The rating with the lowest percentage of families responding positively for the program as a whole was *Getting Care Quickly*, at approximately 70%. For individual plans, the highest score was 94%for *How Well Doctor's Communicate* and *Courteous and Helpful Staff* composites while the lowest score was 63%for the *Getting Care Quickly* composite.

Data on children's health coverage from the National CAHPS® Benchmarking Database Project show that HFP's results were not substantially different from results presented in the 2002 CAHPS® Benchmarking Database for Medicaid and commercial plans. HFP had a higher result for rating of health plan (72% versus 51% and 57% for commercial and Medicaid programs, respectively).

Chairman Allenby asked if there were any questions. Mr. Mendoza asked what MRMIB would do with this data. Ms. Brown responded that the information is included in the subscriber's handbook and used for program evaluation. In addition, the information is shared with the Board, stakeholders and the health and dental plans. This report is a short summary of the actual data the vendor produces for MRMIB. The vendor also provides individual plan information focused on areas of improvement.

Ed Mendoza commented that he was impressed with Medi-Cal's use of data to support its activities to address quality of care in the Medi-Cal program. Ms. Brown stated that MRMIB is developing a quality improvement framework, but has not used the results from this survey due to variations in responses among language groups. Analysis of prior survey results by language revealed that families responding in Asian languages (Chinese, Vietnamese and Korean) rated their experience and satisfaction with plans lower than families responding in English and Spanish. This difference in responses among language groups may contribute to the lower than average satisfaction scores among health plans with a large number of Asian language subscribers. MRMIB is working with RAND to understand the variations in responses among the language groups. MRMIB has not required plans to implement quality improvement projects. However, such projects can be considered for incorporation into new HFP plan contracts. Ms. Cummings commented that the reason MRMIB reconvened the Quality Improvement Work Group was to get ideas to use in the reprocurement process to fuel quality improvement programs in the individual health plans.

Chairman Allenby asked if there were any other questions or comments. There were none.

Dental Plans

Ms. Milberger presented the results of the second annual dental plan survey developed by members of the CAHPS® consortium. No other publicly funded insurance program has used the D-CAHPS® survey to evaluate dental services. The survey was conducted using the Medicaid CAHPS® 2.0H survey protocol.

The Survey's response rate was 46.4 percent, which exceeded the target rate of 45 percent. The survey's results indicated that between 65% to 75% of families rated their dental care, dental plan, personal dentist and specialist an 8, 9 or 10. The highest score achieved for the program was in the *rating of dental care specialist* at 75%. The lowest score achieved for the program was 65%for the *rating of dental plan*. Of the scores achieved by individual plans, 85% was the highest score achieved for the *overall*

rating of dental specialist. The lowest score was approximately 53 % for the *overall rating of dental care*.

Chairman Allenby asked if there were any questions or comments. Ms. Gotlieb commented that it seemed inconsistent for the customer service score to be low while the ranking for office staff was good. Ms. Brown replied customer service was at the plan level while office staff were at the dentist office. She suggested that MRMIB might wish to take steps towards refining the tools used. Ms. Brown responded that RAND is looking into refining the product and the methodology behind the analysis. She is also in contact with other states and the CAHPS Benchmarking Project to find out how the HFP results compare to other programs or private insurers.

Ms. Gotlieb commented that the response rate had barely reached the required level. She noted that the response rate for the health plans was considerably higher. Ms. Brown stated that unlike the health survey there was no telephone follow-up performed with the dental survey and that this follow-up was helpful in achieving a higher response rate. The Contractor did not do a telephone follow-up because the protocol for such follow-up has not yet been developed.

Dr. Crowell stated that it is important to look at the utilization of services, particularly given the significant variation in scores between plan types.

Dr. Hernández commended staff on the groundbreaking work it has done on dental consumer satisfaction. She expressed concern that 47% of the respondents reported that they were not getting needed dental care. MRMIB must continue to focus on improving results.

Chairman Allenby asked if there were any questions or public comment. There were none.

Insurance-based Oral Health Solicitation and Model Contract Amendments

Mauricio Leiva, Benefits Manager, presented for Board approval amendments to the draft solicitation and model contract amendments for the Insurance-based Oral Health Demonstration Project. The first draft of the solicitation and model contract amendments were presented to the Board at its April meeting. With the Board's approval of the final draft, MRMIB will release the solicitation document and model contract to all interested parties. A bidder's conference is scheduled on May 29, 2003, from 1:00 p.m. to 3:00 p.m.

The contract results from a partnership formed by the "First 5 California Children and Families Commission" (Proposition 10) and MRMIB. The First 5 Children and Families Commission is implementing a statewide oral health initiative to reduce the incidence of dental decay among young children. The component that MRMIB has been asked to administer is the Insurance-based Oral Health Demonstration Project. Health and dental plans currently participating in the HFP are being asked to collaborate with

MRMIB and submit proposals addressing the goals and objectives of the Demonstration Project.

During the past 30 days, MRMIB has received comments from the Staff at the California Children and Families Commission (CFCC); County Children and Families Commissions; the California Primary Care Association, and the Dental Health Foundation. Mr. Leiva expressed his gratitude to those organizations with special thanks to the staff from the State California Children and Families Commission.

Mr. Leiva reviewed the most significant changes made to the draft:

The term of the proposal solicitation was changed from three years to one (fiscal year 2003-2004) only. This change is necessary to conform the process with the timing for reprocurement of HFP plan contracts which will take effect July 1, 2004. Language has been added that outlines options for continuing the demonstration projects in fiscal year 2004-2005 and 2005-2006. These options include conducting another proposal solicitation for each fiscal year or extending the contract. Ms. Cummings added that MRMIB is interested in projects that can last more than a year.

Language has been added requiring the contractors' participation in a third-party evaluation. Ms. Brown noted that the CFCC has required an independent evaluation as part of the project. Enclosure A outlines the independent third party evaluation, including research design and data collection requirements.

Additional language emphasizes the need for contractors to serve children with disabilities and other special needs.

Chairman Allenby asked if there were any questions or public comment.

Dr. Hernández noted that the draft referred to “school readiness”. She asked what that entailed. Mr. Leiva responded that Proposition 10 works with low performing schools to develop proposals to address its programs. The projects would be coming through dental clinics that would work closely with the schools. The clinics will be part of the dental and health plan networks. Mr. Mendoza asked whether the goal of the project was clinical prevention or population-based prevention. Ms. Brown replied that the MRMIB project was to increase access. A separate project also funded by CCFC is more population based.

Chairman Allenby made a motion to approve the solicitation and model contract. Virginia Gotlieb seconded and the motion was unanimously passed.

Copayment Report

Doug Skarr, Research Program Specialist, presented the Copayment Report. This annual report provides a summary and analysis of families who reached the maximum

allowed health copayment for the prior benefit year. This report covers the 2001/02 benefit year..

Federal law (Title XXI) limits the sum of premiums plus copayment expenses a family can pay to no more than 5% of household income. California has assured compliance with this requirement by restricting the amount of copayments for health services to no more than $250 per family per benefit year. Once a family has reached this limit, they are no longer required to make copayments for their health services that year. There are no state limits on copayments for dental and vision services.

The percentage of families reaching the $250 copayment maximum for health services was .087 percent. This is the third year in a row that the percentage has been less than a tenth of one percent. No family with a household income between 150% - 200% of FPL paid 5% or more of their income for health insurance copayments. Families with household incomes below 150% FPL that reached copayment limit averaged less than 1.5% of income for out-of-pocket expense for combined premiums and copayments.

Chairman Allenby commented that subscribers reaching the copayment limit were clearly active users of the program. Ms. Gotlieb asked if the ethnic variation in percentage reaching the limit shown in Table 3 was due to record keeping. Mr. Skarr replied it was difficult to determine based on the small sample size of 257.
Dr. Hernández asked why, according to Table 1, there was such significant variation by plan. Ms. Brown noted that families have to keep records of their copayments to document that they have met the limit. This documentation might be easier in certain plans.

Dr. Hernández commented that there might be many more families reaching this maximum that are not recorded. There are two worrisome indicators – ethnicity variance and the predominance that one particular plan had in families who reached the maximum. MRMIB may be meeting its requirements, but what can be done to assist families who may not know they are reaching the maximum? Dr. Crowell asked if plans could keep track of copayments for families. Dr. Hernandez thanked the staff for producing a great report.

Chairman Allenby asked if there were any questions or public comment. There were none.

Health Plan Quality Corrective Action Plan

Doug Skarr, Research Program Specialist for MRMIB, presented the results of the Quality Performance Improvement Project. This project was initiated by a request from the Board at its November public meeting. At that time, staff presented the Healthy Families Program 2001 Quality Report, which outlined quality performance for HFP participating plans in five areas. The performance results for the program as a whole were at or above national benchmarks for both commercial and Medicaid plans. However, the scores related to adolescent well visits and mental health follow-up were

very low. Based on these findings, the Board requested staff to do further analysis to identify plan performance that warranted improvement and provide feedback to the plans on their performance.

Mr. Skarr reviewed in detail the approach staff has developed to address quality improvement with the plans. The approach uses a specific method to identify high and low performing plans. High performing plans will be acknowledged in writing for their superior performance and requested to provide staff with information on the successful practices they have used to achieve either above average results and/or improvements from the prior year. Low performing plans will be requested to provide their strategy and timeline for improving performance for the measures. All plans will be required to submit corrective action plans for improving performance in the adolescent well visits and mental health measures.

Ms. Gotlieb commented that this was a fascinating report. Dr. Crowell stated this was exactly what the Board had asked for and the Board expected plans to take the results seriously. Mr. Skarr stated that this report had also been presented to the Quality Improvement Work Group (QIWG) at its last meeting. Chairman Allenby commented that the variances in score were disconcerting. Ms. Brown replied that the QIWG is looking at establishing performance thresholds that plans would be required to meet. Chairman Allenby stated that, in the future, MRMIB could impose a certain level and not allow plan participation in HFP for those plans that do not reach it. Dr. Hernández indicated that staff should think about how to provide incentives for plans that are good performers beyond asking them to provide their best practices.

Mr. Mendoza asked if certain of the measures were more important than others. Mr. Skarr replied that there were seven measures total and all were equally important. Mr. Mendoza asked why the immunization measure was not listed in the measurement tool. Mr. Skarr replied that sample sizes for the immunization and mental health measures had been too small to make any inference from the data. Mr. Mendoza noted that childhood immunizations are nationally ranked as being important measures. Ms. Brown agreed that the immunization measure was important and that there were totals for most plans, but some did not have a sufficient sample to meet NCQA guidelines. There will be a suitable sample size for inclusion next year.

Mr. Mendoza asked what the return on investment was for plans that provide the best practices. Ms. Brown responded that the QIWG is looking into ways to provide incentives for best practices. They are mindful that budget restraints require creativity in doing so. Dr. Hernández commented that it is evident that two plans are low performers.

Chairman Allenby asked if there were any other questions or comments. There were none.

County Mental Health Services for Seriously Emotionally Disturbed (SED) Status Report

Vallita Lewis, Program Policy and Evaluation Manager, reviewed the annual status report on county mental health services for Healthy Families Program children who are diagnosed as seriously emotionally disturbed (SED). This report covers the 2001/2002 benefit year. It provides information on the number of referrals health plans made to county mental health departments for SED, the number of active SED cases by county, the dollars expended, and the types of mental health services utilized through the county mental health systems.

Ms. Lewis reviewed the number of referrals reported by each plan. She noted that the information did not reflect all SED referrals as referrals could come from other sources besides health plans, such as the school, families and community agencies. In the 2001/2002 benefit year, there were 9 plans with a decrease in referrals, while there were 8 plans that showed an improvement or increase in the number of referrals as a percentage of their total HFP enrollment. The net effect is that the total number of referrals decreased slightly from 1,098 to 942. As a percentage of total HFP enrollments, referrals decreased form 0.24% to 0.2%. Mr. Mendoza asked if this was statistically significant. Ms. Brown replied that it did not appear to be significant.

Ms. Lewis reviewed the number of active HFP SED cases in each county. In benefit year 2001/2002 there were over 3,500 active cases. This represents 0.6% of HFP enrollments and a 0.1 percentage point increase in comparison to the prior benefit year. Ms. Lewis reviewed the age distribution of active SED cases. She noted that the Board had expressed interest in knowing the ages of the HFP's children receiving SED services when this report was presented last year. Eighty-six percent of the children receiving SED services are 8 years of age or older. The number of active cases of children in the 8-18 age group represented 0.93% of HFP subscribers in the same age group. Fifteen-year-old subscribers had the largest total number of active cases, comprising approximately one out of every 11 cases. This represents approximately 1.5% of all 15-year-olds enrolled in the program. Younger children ages 1-4 who fit the SED criteria accounted for 3% of the HFP children receiving SED services.

Ms. Lewis reviewed SED expenditures by fiscal year and noted that they increased dramatically from fiscal years 1998/99 through 2001/2002. The 2001/2002 expenditure of $11.3 million is almost double the $5.8 million expenditure for the prior year and is greater than the $8.4 million combined total for the prior three fiscal years. The average cost per case has increased by 17%. The increase in expenditures may be partially due to the fact that counties are becoming more knowledgeable about the claiming process and are billing more successfully. The counties also have a financial incentive to identify HFP children who are receiving services as they receive federal matching dollars. Several counties with a large HFP population (including Orange, Santa Clara and Ventura) continue to report zero active cases and expenditures. MRMIB staff contacted these counties and learned that they did have (unreported) active SED cases for HFP subscribers. These counties indicated they are not reporting expenditures due

to a number of reasons such as delays in implementing a new electronic system to process claims; claims not submitted correctly and other difficulties with the claiming process. The counties indicated they are working on solutions to these problems. Chairman Allenby commented that there are well known disparities in county reporting.

Ms. Lewis reviewed the claims paid by type of service. For both the 2000/2001 and the 2001/2002 Benefit year, "Mental Health Services" accounted for over 70% of claims paid. Mental health services include assessment, individual and group therapy, plan development and rehabilitation.

Ms. Lewis summarized that, while the number of active SED cases has increased each year, MRMIB is still concerned about the continuing low rate of referrals and utilization of mental health services. As a result, MRMIB will pursue funding for an independent study to determine whether the coordination of the mental health services between the health plans and county mental health departments is functioning effectively. MRMIB staff continues to take a proactive role in working with the health plans and the counties in coordinating mental health services. Ms. Lewis thanked Alice Chan of MRMIB and Ericka Cristo of the Department of Mental Health for their assistance in the preparation of this report.

Chairman Allenby asked if there were questions or comments.

Dr. Hernández asked if the "carve out" is working for HFP children. Children in the HFP may not be getting appropriate services for their mental health needs. If MRMIB is going to pursue a study, she recommended that its focus be restructured to focus on this fundamental question. Some of the system's problems may be attributed to processes between the counties and the plans. But a major factor is that counties are facing severe budget constraints which affect their ability to provide service. An independent study should recognize parts of the "carve out" that are not working. Chairman Allenby commented that Dr. Hernandez made an excellent point. It is hard when the responsibilities for providing services are spread out and one of the parties is not in good shape.

Chairman Allenby asked if there were any further questions or comments. There were none.

Update on the Quality Improvement Work Group

Lorraine Brown presented an update on the progress the Work Group is making towards developing its recommendations on quality assessment and improvement activities for the HFP. There have been two work groups meetings and two subcommittee meetings since the Work Group reconvened in January. The first meeting in February reoriented the members with respect to their initial recommendations and the key issues MRMIB is interested in having the work group address. Four key issues include new or existing quality indicators, collection of health and dental plan encounter data, use of performance targets, and health plan

accreditation as a quality accountability tool. The second meeting in April discussed a list of performance measures MRMIB could consider using to assess health plan quality. New measures considered include mental health utilization, chemical dependency utilization, and the percent of children and adolescents reporting days lost from school. This last measure is consistent with the findings of the Health Status Assessment study. Two surveys are also being considered – Young Adult Health Care Survey and the Promoting Healthy Development Survey. The group will meet again in July.

Mr. Mendoza asked if weight management issues were being considered by the group. Dr. Hernández added that this is a complex area and it would be interesting to know how many HFP enrollees are considered obese children. This area may require more of a public health intervention other than intervention from the primary care provider. A program that targets children could be important in terms of finding out how a health problem may affect a population.

Chairman Allenby asked if there were any other questions or comments. There were none.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Mr. Sanchez presented the AIM subscriber data for May 2003. There are currently 5,029 mothers and 9,975 infants enrolled in the program. Mr. Sanchez briefly reviewed enrollment data that included ethnicity and the counties with the highest percentage of enrollment.

Chairman Allenby asked if there were any questions or public comment; there were none.

Fiscal Report

Tom Williams presented the AIM fiscal summary. For the period from July 1, 2002, through April 30, 2003; available revenues were $94,891,000 and total expenditures were $77,931,753.

Chairman Allenby asked if there were any questions or public comment. There were none.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Mr. Sanchez presented the MRMIP data for May 2003. There are 16,231 people enrolled in the program of whom 2,598 were newly enrolled during FY 02-03.

Mr. Sanchez briefly reviewed the percentage of enrollment by selected counties, age, gender, and ethnicity. As of May 19, 2003, the MRMIP waiting list is 113 persons due to the post-enrollment waiting period requirement. Chairman Allenby asked if there were any questions or public comment; there were none.

Fiscal Report

Mr. Williams presented the MRMIP fiscal summary. For the period from July 1, 2002, through March 31, 2003, program expenditures were $105,592,736.

Revised Enrollment Estimate

Joyce Iseri, Chief Deputy Director, reported that PricewaterhouseCoopers (PwC) revised its enrollment estimate from the one provided at the April meeting to take into account MRMIB's decision to keep enrollment open. The current enrollment cap is 16,686. PwC is now recommending a target of 16,358 prior to September 1, 2003 (when the incubator takes effect) and a target of 9,990 for the remainder of the year.

Chairman Allenby asked if there were any questions or public comment; there were none.

Executive Session

Board members Dr. Areta Crowell and Virginia Gotlieb were not able to attend the executive session. Chairman Allenby made a motion not to hold the executive session in their absence. The motion was unanimously passed.

There being no further discussion to come before the Board, the meeting was adjourned.